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Medication Errors and Hospital Admissions, a Tale of Woe

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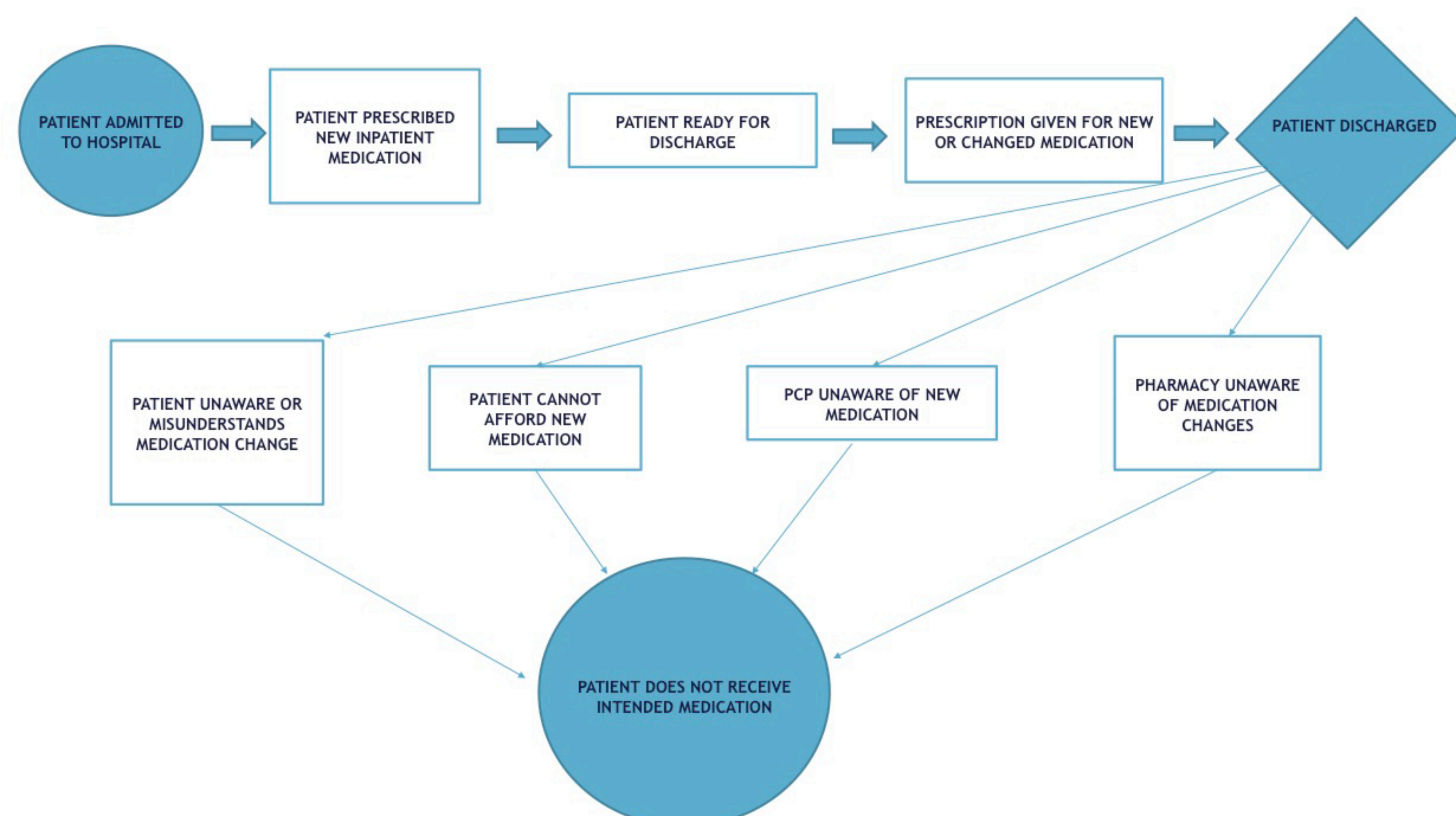
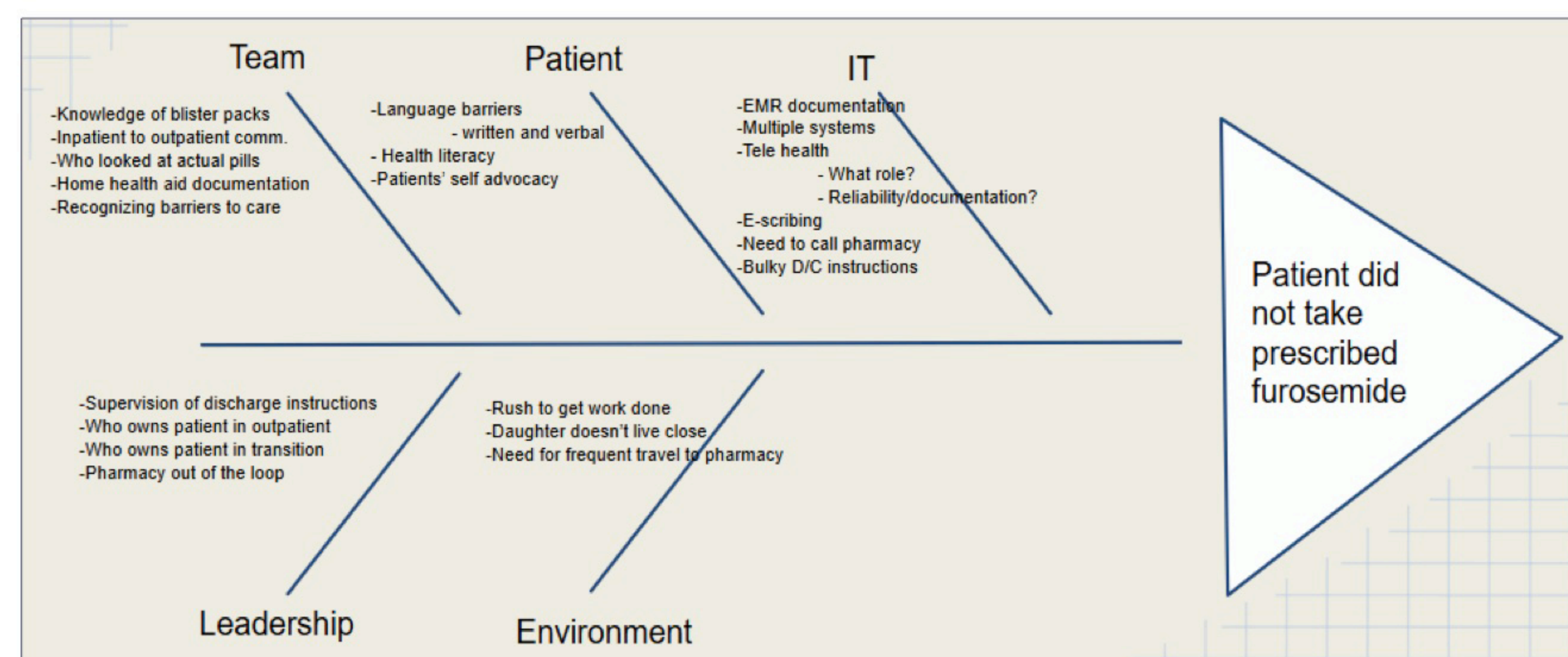
Medication Errors and Hospital Admissions, a Tale of Woe

Allison Greco, M.D., Rene Daniel, M.D., and Raymond Janowski, M.D.
Bracken Babula, M.D.

CASE DESCRIPTION

- Elderly Spanish-speaking patient presents to ED with CHF exacerbation
- Given home dose of Lasix with a good response, discharged without prescription
- One week later calls with worsening symptoms, told to double dose, no prescription given
- Readmitted one week after with CHF exacerbation, given home dose, discharged again without prescription
- Follow-up phone call reveals patient had not received Lasix in pharmacy blister packs for two months

CAUSE ANALYSIS



GOAL FOR IMPROVEMENT

- TO improve proper medication regimens for patients as they transition between healthcare settings
- SO THAT patients achieve improved outcomes and reduced hospital admissions caused by medication errors
- SMART aim is to decrease the number of discrepancies between discharge medication lists and pill bottles or blister packs produced at one-week follow up with Jefferson PCP by 10% within six months**

PROPOSED INTERVENTION

- Force function for inpatient team-to-PCP communication at discharge highlighting key medication changes
- Multidisciplinary team approach to medication reconciliation including pharmacy and social work to ensure patient can afford and understand new medications
- Section for identification of patient's pharmacy on H&P and mandatory communication with patient's pharmacy on admission for early identification of patients at high risk for medication error

NEXT STEPS

- Identify key stakeholders in pharmacy and social work departments to form multidisciplinary team to implement interventions
- Meet with IT representatives to establish channel for data collection in EPIC
- Identify pilot group of patients on hospital medicine service with Jefferson primary care providers